Verifying Eligibility: Medical Assistance Identification Cards

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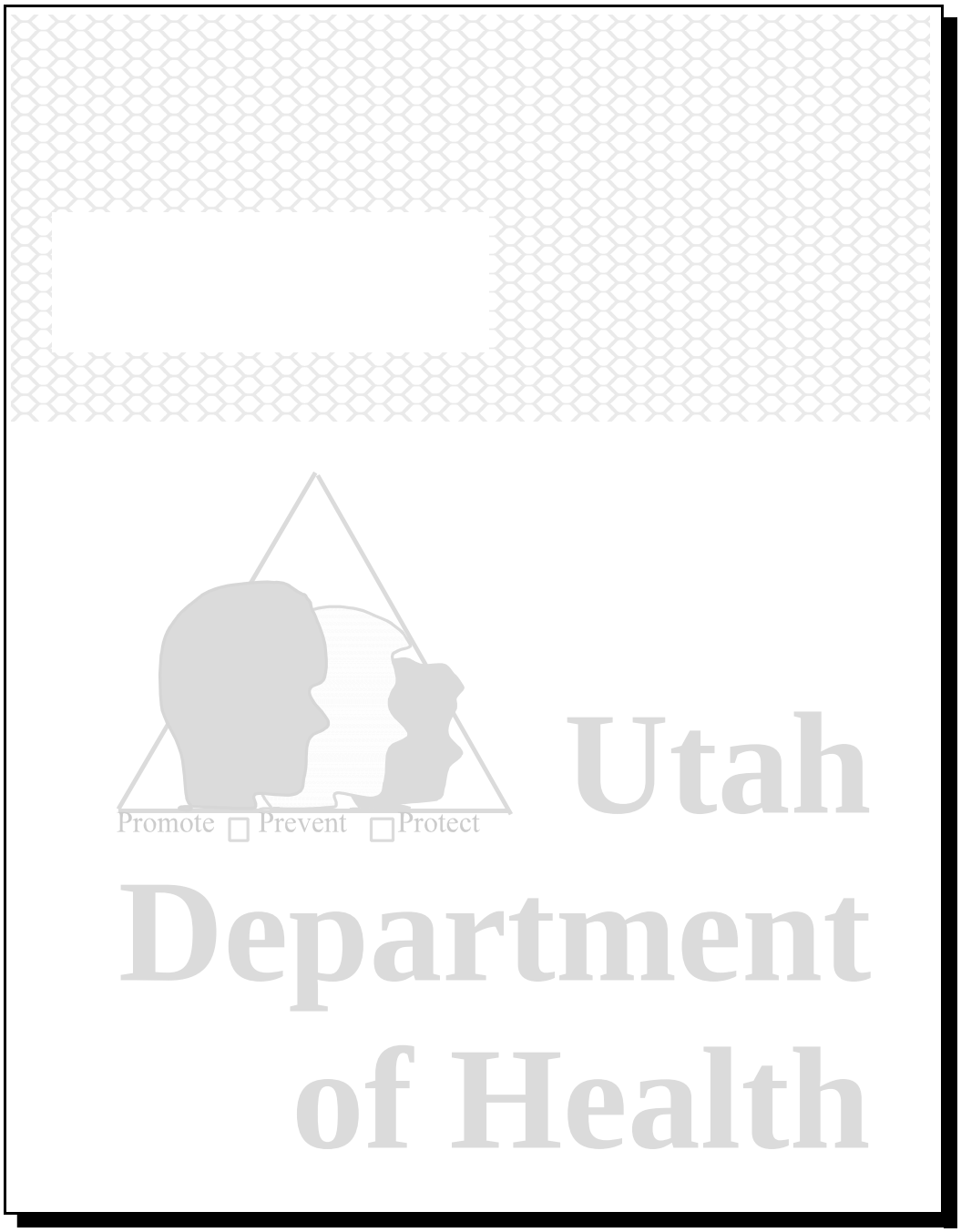
DEPARTMENT OF HEALTH LOGO

Below is a sample of the Department of Health logo that is printed on the cardstock used for Medical Identification Cards. The color of the background and logo varies depending on the type of card.



INFORMATION ON MEDICAID IDENTIFICATION CARD

Below is a sample Medicaid Identification Card. The top third of the card is a tear-away with the client's name and address. The Card is printed on white card stock with lavender background behind the name and address and a lavender logo for the Department of Health on the background. The numbers in circles on the example card below correspond to the explanation to the left of the card.
Reference: Utah Medicaid Provider Manual, SECTION 1, Chapter 5, Verifying Medicaid Eligibility.

Ø Dates of Medicaid eligibility
Ù Types of services covered
Ú ***H**ealth **M**aintenance **O**rganization indicator
Û **T**hird **P**arty **L**iability (insurance) indicator
Ü Client name
Ý Medicaid Identification Number
Þ Sex is M or F: male/female
ß Date of birth
à Age
á ***Medical Provider: HMO or Primary Care Provider
⓫ **Pharmacy provider
⓬ **Dental care provider
⓭ ***Mental health services provider
⓮ Copayment/co-insurance indicators for certain types of services.
⓯ TPL information
⓰ Additional Medicaid clients
⓱ (F) indicates a client entitled to the FULL scope of Medicaid services,
⓲ Information for Medicaid client
⓳ Information for Medicaid Provider

***When a health care provider is identified for a service type, the client must use that provider.
****Managed care plans do not cover pharmacy, dental, or chiropractic services. Card states "A participating physician/ pharmacist/dentist." The client may choose a provider who accepts Medicaid for the service needed.

DEPARTMENT OF WORKFORCE SERVICES
158 SOUTH 200 WEST
P.O. BOX 45490
SALT LAKE CITY UT 84145

NON-NEGOTIABLE

JANE DOE
1234 FIRST STREET
ANYTOWN UT 84000

NON-NEGOTIABLE

MEDICAID IDENTIFICATION CARD
UTAH DEPARTMENT OF HEALTH

Ø ELIGIBLE FROM - JUNE 1, 2002 THRU JUNE 30, 2002

Ù THIS ID CARD ENTITLES THE FOLLOWING NAMED PERSONS TO MEDICAL/DENTAL/PHARMACY SERVICES.

Ú HMO Û TPL HMO TPL HMO

Ü NAME	Ý ID	Þ SEX	ß DOB	à AGE	á ⓫ MEDICAL/PHARMACY
DOE, JANE	9999999999	F	01APR60	42	HMO or Primary Care Physician
					⓬ DENTAL Dental care provider
					⓭ MENTAL HEALTH SERVICES Mental health services provider

⓮ COPAY/CO-INS FOR: NON EMERGENCY USE OF ER, OUTPAT HOSP & PHYSICIAN SVCS, PHARMACY INPAT HOSP
⓯ THIRD PARTY: MAILHANDLERS
POLICY HOLDER: DOE, JOHN

⓰ DOE, JOHN 9999999999 M 01APR82 20 MEDICAL/PHARMACY
THIRD PARTY: MAILHANDLERS — HMO or Primary Care Physician
POLICY HOLDER: DOE, JOHN — DENTAL
⓮ NO CO-PAYMENT REQUIRED — Dental care provider
MENTAL HEALTH SERVICES
Mental health services provider

---------- ⓱ ----------

⓰ DOE, BLANE 9999999999 (F) M 01APR87 15 MEDICAL/PHARMACY
THIRD PARTY: MAILHANDLERS — HMO or Primary Care Physician
POLICY HOLDER: DOE, JOHN — DENTAL
⓮ NO CO-PAYMENT REQUIRED — Dental care provider
MENTAL HEALTH SERVICES
Mental health services provider

* *

⓲ CLIENT: THIS CARD MUST BE PRESENTED BEFORE RECEIVING MEDICAID SERVICES. PLEASE KEEP THIS CARD FOR YOUR RECORDS. IF YOU HAVE QUESTIONS ON MEDICAL COVERAGE CALL MEDICAID AT 1-800-662-9651. IF YOU HAVE QUESTIONS ON MENTAL HEALTH COVERAGE CALL [Prepaid Mental Health Plan] AT [PMHP phone number]. FOR NON-EMERGENCY TRANSPORTATION SERVICES CALL 1-888-822-1048. IF YOU HAVE QUESTIONS REGARDING THE USE OF THIS CARD OR QUESTIONS ON DENTAL OR PHARMACY, PLEASE CONTACT MEDICAID INFORMATION AT 538-6155 OR TOLL FREE AT 1-800-662-9651. ANY ATTEMPT TO MODIFY THIS CARD IN ANY WAY OR ALLOW USE BY UNAUTHORIZED PERSONS CONSTITUTES FRAUD.
⓳ PROVIDER: IF THERE ARE ANY CHANGES ON INSURANCE COVERAGE, CALL THE TPL UNIT AT 1-800-821-2237. PLEASE KEEP A COPY OF THIS CARD FOR YOUR RECORDS. THIS IS THE END OF THE MEDICAID IDENTIFICATION CARD. **000191919 FM

FEE-FOR-SERVICE MEDICAID CARD

This Medicaid Identification Card has no health maintenance organization or Primary Care Provider identified. The client may receive services from any Medicaid provider of medical, dental, or pharmacy services. Standard information is explained with an example on page 3. Information unique to the Fee-for-Service Card is marked with a numbered circle. Refer to explanation of numbers below.

Reference: Utah Medicaid Provider Manual, SECTION 1, Chapter 3, Fee-For-Service Medicaid.

DEPARTMENT OF WORKFORCE SERVICES
158 SOUTH 200 WEST
P.O. BOX 45490
SALT LAKE CITY UT 84145

NON-NEGOTIABLE

JANE DOE
1234 FIRST STREET
ANYTOWN UT 84000

NON-NEGOTIABLE

MEDICAID IDENTIFICATION CARD

UTAH DEPARTMENT OF HEALTH

ELIGIBLE FROM - JUNE 1, 2002 THRU JUNE 30, 2002

THIS ID CARD ENTITLES THE FOLLOWING NAMED PERSONS TO MEDICAL/DENTAL/PHARMACY SERVICES.

TPL	TPL	TPL	TPL	TPL
NAME	ID	SEX	DOB	AGE
DOE, JANE	9999999999	F	01APR64	40

CO-PAYMENT REQUIRED FOR NON EMERGENCY USE OF THE ER ROOM
THIRD PARTY: MAILHANDLERS
POLICY HOLDER: DOE, JOHN

DOE, JOHN 9999999999 M 01APR82 20
THIRD PARTY: MAILHANDLERS
POLICY HOLDER: DOE, JOHN
NO CO-PAYMENT REQUIRED

DOE, BLANE 9999999999 (F) M 01APR87 15
THIRD PARTY: MAILHANDLERS
POLICY HOLDER: DOE, JOHN
NO CO-PAYMENT REQUIRED

* *

CLIENT: THIS CARD MUST BE PRESENTED BEFORE RECEIVING MEDICAID SERVICES. PLEASE KEEP THIS CARD FOR YOUR RECORDS. IF YOU HAVE QUESTIONS ON MEDICAL COVERAGE CALL MEDICAID AT 1-800-662-9651. IF YOU HAVE QUESTIONS ON MENTAL HEALTH COVERAGE CALL [Prepaid Mental Health Plan] AT [PMHP phone number]. FOR NON-EMERGENCY TRANSPORTATION SERVICES CALL 1-888-822-1048. IF YOU HAVE QUESTIONS REGARDING THE USE OF THIS CARD OR QUESTIONS ON DENTAL OR PHARMACY, PLEASE CONTACT MEDICAID INFORMATION AT 538-6155 OR TOLL FREE AT 1-800-662-9651. ANY ATTEMPT TO MODIFY THIS CARD IN ANY WAY OR ALLOW USE BY UNAUTHORIZED PERSONS CONSTITUTES FRAUD.

PROVIDER: IF THERE ARE ANY CHANGES ON INSURANCE COVERAGE, CALL THE TPL UNIT AT 1-800-821-2237. PLEASE KEEP A COPY OF THIS CARD FOR YOUR RECORDS. THIS IS THE END OF THE MEDICAID IDENTIFICATION CARD.**********000191919FM

Ø No health care providers are identified. Client may use any medical, pharmacy, dental, or mental health service provider who accepts Medicaid for the service needed.

IHC ACCESS

This Medicaid Identification Card states the name of a Preferred Provider Network below eligibility information and above the client's name. When a client's Medicaid card states IHC ACCESS as the health plan, the client must use IHC ACCESS hospitals and doctors. Beginning October 1, 2002, for other types of services, clients may use any provider, regardless of IHC affiliation. For all services, providers should follow the fee-for-services guidelines for billing, prior authorization, complaints, grievances, etc. [SECTION 1 of the Utah Medicaid Provider Manual, Chapter 3, Fee-for-service Medicaid] For example, a provider should contact Medicaid, not IHC, when a service for an IHC Access member requires preauthorization. [SECTION 1, Chapter 9, Prior Authorization].
Provider should submit claims for IHC Access members with a date of service on or after October 1, 2002, to Medicaid for reimbursement, not to IHC Access. Submit claims electronically, as per SECTION 1, Chapter 11, Billing Claims.

Standard information is explained with an example on page 3. Information unique to the IHC Access Card is marked with a numbered circle. Refer to explanation of numbers below.

Reference: Utah Medicaid Provider Manual, SECTION 1, Chapters 3, Fee-for-service Medicaid, and 4, Managed Care Plans.

Ø Preferred Provider Network indicator

Ù Hospital and doctor services covered by IHC Access

DEPARTMENT OF WORKFORCE SERVICES
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P.O. BOX 45490
SALT LAKE CITY UT 84145

NON-NEGOTIABLE

JANE DOE
1234 FIRST STREET
ANYTOWN UT 84000

NON-NEGOTIABLE

MEDICAID IDENTIFICATION CARD
UTAH DEPARTMENT OF HEALTH

ELIGIBLE FROM - JUNE 1, 2002 THRU JUNE 30, 2002

THIS ID CARD ENTITLES THE FOLLOWING NAMED PERSONS TO MEDICAL/DENTAL/PHARMACY SERVICES.

Ø **I.H.C ACCESS** **I.H.C. ACCESS** **I.H.C. ACCESS**

NAME	ID	SEX	DOB	AGE		MEDICAL/PHARMACY
DOE, JANE	9999999999	F	01APR37	65	Ù	IHC Access
						MENTAL HEALTH SERVICES
						VALLEY MENTAL HEALTH

COPAYMENT REQUIRED FOR PHARMACY
* *

CLIENT: THIS CARD MUST BE PRESENTED BEFORE RECEIVING MEDICAID SERVICES. PLEASE KEEP THIS CARD FOR YOUR RECORDS. IF YOU HAVE QUESTIONS ON MEDICAL COVERAGE CALL MEDICAID AT 1-800-662-9651. IF YOU HAVE QUESTIONS ON MENTAL HEALTH COVERAGE CALL [Prepaid Mental Health Plan] AT [PMHP phone number]. FOR NON-EMERGENCY TRANSPORTATION SERVICES CALL 1-888-822-1048. IF YOU HAVE QUESTIONS REGARDING THE USE OF THIS CARD OR QUESTIONS ON DENTAL OR PHARMACY, PLEASE CONTACT MEDICAID INFORMATION AT 538-6155 OR TOLL FREE AT 1-800-662-9651. ANY ATTEMPT TO MODIFY THIS CARD IN ANY WAY OR ALLOW USE BY UNAUTHORIZED PERSONS CONSTITUTES FRAUD.

PROVIDER: IF THERE ARE ANY CHANGES ON INSURANCE COVERAGE, CALL THE TPL UNIT AT 1-800-821-2237. PLEASE KEEP A COPY OF THIS CARD FOR YOUR RECORDS. THIS IS THE END OF THE MEDICAID IDENTIFICATION CARD.**********000191919 AM

HMO: AMERICAN FAMILY CARE OF UTAH (AFC)

This Medicaid Identification Card states name of health maintenance organization (HMO) below eligibility information and above the client's name. Card is not valid for services from any other health care supplier or provider (HMO, physician, hospital facility, home health, medical supplier, etc.) without a referral from the HMO identified. Pharmacy and dental services may be provided by any Medicaid participating pharmacist/dentist. Standard information is explained with an example on page 3. Information unique to the AFC Card is marked with a numbered circle. Refer to explanation of numbers below.

Reference: Utah Medicaid Provider Manual, SECTION 1, Chapter 4, Managed Care Plans.

Ø HMO and TPL indicators

Ù Medical services covered by the managed care plan.
*Managed care plans do not cover pharmacy, dental, or chiropractic services. The client may choose a provider who accepts Medicaid for the service needed.

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158 SOUTH 200 WEST
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SALT LAKE CITY UT 84145

NON-NEGOTIABLE

JANE DOE
1234 FIRST STREET
ANYTOWN UT 84000

NON-NEGOTIABLE

MEDICAID IDENTIFICATION CARD
UTAH DEPARTMENT OF HEALTH

ELIGIBLE FROM - JUNE 1, 2002 THRU JUNE 30, 2002
THIS ID CARD ENTITLES THE FOLLOWING NAMED PERSONS TO MEDICAL/DENTAL/PHARMACY SERVICES.

Ø AFC-Utah TPL				AFC-Utah TPL	
NAME	ID	SEX	DOB	AGE	MEDICAL/PHARMACY
DOE, JANE	9999999999	F	01APR92	10	Ù AFC

DENTAL
NO CO-PAYMENT REQUIRED
A participating dentist
MENTAL HEALTH SERVICES
VALLEY MENTAL HEALTH

THIRD PARTY: PEHP
POLICY HOLDER: John Doe
****

CLIENT: THIS CARD MUST BE PRESENTED BEFORE RECEIVING MEDICAID SERVICES. PLEASE KEEP THIS CARD FOR YOUR RECORDS. IF YOU HAVE QUESTIONS ON MEDICAL COVERAGE CALL MEDICAID AT 1-800-662-9651. IF YOU HAVE QUESTIONS ON MENTAL HEALTH COVERAGE CALL [Prepaid Mental Health Plan] AT [PMHP phone number]. FOR NON-EMERGENCY TRANSPORTATION SERVICES CALL 1-888-822-1048. IF YOU HAVE QUESTIONS REGARDING THE USE OF THIS CARD OR QUESTIONS ON DENTAL OR PHARMACY, PLEASE CONTACT MEDICAID INFORMATION AT 538-6155 OR TOLL FREE AT 1-800-662-9651. ANY ATTEMPT TO MODIFY THIS CARD IN ANY WAY OR ALLOW USE BY UNAUTHORIZED PERSONS CONSTITUTES FRAUD.

PROVIDER: IF THERE ARE ANY CHANGES ON INSURANCE COVERAGE, CALL THE TPL UNIT AT 1-800-821-2237. PLEASE KEEP A COPY OF THIS CARD FOR YOUR RECORDS. THIS IS THE END OF THE MEDICAID IDENTIFICATION CARD.**********000191919 FC

HMO: AFC - PLUS

This Medicaid Identification Card states name of health maintenance organization (HMO) below eligibility information and above the client's name. Card is not valid for services from any other health care supplier or provider (HMO, physician, hospital facility, home health, medical supplier, etc.) without a referral from the HMO identified. Pharmacy and dental services may be provided by any Medicaid participating pharmacist/dentist. Standard information is explained with an example on page 3. Information unique to the AFC - PLUS Card is marked with a numbered circle. Refer to explanation of numbers below.

Reference: Utah Medicaid Provider Manual, SECTION 1, Chapter 4, Managed Care Plans.

DEPT OF WORKFORCE SERVICES
40 SOUTH 200 EAST
ST GEORGE UT 84770-2831

NON-NEGOTIABLE

JANE DOE
1234 FIRST STREET
ST GEORGE UT 84770-2831

NON-NEGOTIABLE

MEDICAID IDENTIFICATION CARD
UTAH DEPARTMENT OF HEALTH

ELIGIBLE FROM - JUNE 1, 2002 THRU JUNE 30, 2002

THIS ID CARD ENTITLES THE FOLLOWING NAMED PERSONS TO MEDICAL/DENTAL/PHARMACY SERVICES.

Ø **AFC-PLUS** **TPL** **AFC-PLUS** **TPL**

NAME	ID	SEX	DOB	AGE	MEDICAL/PHARMACY
DOE, JANE	9999999999	F	01APR72	30	Ù AFC-PLUS

DENTAL
A participating dentist
MENTAL HEALTH SERVICES
SOUTHWEST MENTAL HEALTH

THIRD PARTY: PEHP
POLICY HOLDER: John Doe

DOE, JOHN 9999999999 M 01APR83 19 MEDICAL/PHARMACY
THIRD PARTY: MAILHANDLERS AFC-PLUS
POLICY HOLDER: DOE, JOHN
DENTAL
A participating dentist
MENTAL HEALTH SERVICES
SOUTHWEST MENTAL HEALTH

****

CLIENT: THIS CARD MUST BE PRESENTED BEFORE RECEIVING MEDICAID SERVICES. PLEASE KEEP THIS CARD FOR YOUR RECORDS. IF YOU HAVE QUESTIONS ON MEDICAL COVERAGE CALL MEDICAID AT 1-800-662-9651. IF YOU HAVE QUESTIONS ON MENTAL HEALTH COVERAGE CALL [Prepaid Mental Health Plan] AT [PMHP phone number]. FOR NON-EMERGENCY TRANSPORTATION SERVICES CALL 1-888-822-1048. IF YOU HAVE QUESTIONS REGARDING THE USE OF THIS CARD OR QUESTIONS ON DENTAL OR PHARMACY, PLEASE CONTACT MEDICAID INFORMATION AT 538-6155 OR TOLL FREE AT 1-800-662-9651. ANY ATTEMPT TO MODIFY THIS CARD IN ANY WAY OR ALLOW USE BY UNAUTHORIZED PERSONS CONSTITUTES FRAUD.
PROVIDER: IF THERE ARE ANY CHANGES ON INSURANCE COVERAGE, CALL THE TPL UNIT AT 1-800-821-2237. PLEASE KEEP A COPY OF THIS CARD FOR YOUR RECORDS.
THIS IS THE END OF THE MEDICAID IDENTIFICATION CARD.**********000191919 FM

Ø HMO and TPL indicators

Ù Medical services covered by the managed care plan.
*Managed care plans do not cover pharmacy, dental, or chiropractic services. The client may choose a provider who accepts Medicaid for the service needed.

HMO: UNITED MEDCHOICE

This Medicaid Identification Card states name of Health Maintenance Organization (HMO) below eligibility information and above the client's name. Card is not valid for services from any other health care supplier or provider (HMO, physician, hospital facility, home health, medical supplier, etc.) without a referral from the HMO identified. Pharmacy and dental services may be provided by any Medicaid participating pharmacist/dentist. Standard information is explained with an example on page 3. Information unique to the United MedChoice Card is marked with a numbered circle. Refer to explanation of numbers below.

Reference: Utah Medicaid Provider Manual, SECTION 1, Chapter 4, Managed Care Plans.

NOTE: Effective September 1, 2002, UNITED MEDCHOICE no longer covers Medicaid clients.

DEPARTMENT OF WORKFORCE SERVICES
158 SOUTH 200 WEST
P.O. BOX 45490
SALT LAKE CITY UT 84145

NON-NEGOTIABLE

JANE DOE
1234 FIRST STREET
ANYTOWN UT 84000

NON-NEGOTIABLE

MEDICAID IDENTIFICATION CARD

UTAH DEPARTMENT OF HEALTH

ELIGIBLE FROM - JUNE 1, 2002 THRU JUNE 30, 2002

THIS ID CARD ENTITLES THE FOLLOWING NAMED PERSONS TO MEDICAL/DENTAL/PHARMACY SERVICES.

Ø United MedChoice **United MedChoice** **United MedChoice**

NAME	ID	SEX	DOB	AGE		MEDICAL/PHARMACY
DOE, JANE	9999999999	F	01APR37	65	Ù	United MedChoice

DENTAL
A participating dentist
MENTAL HEALTH SERVICES
VALLEY MENTAL HEALTH

Copayment Required for Pharmacy

* *

CLIENT: THIS CARD MUST BE PRESENTED BEFORE RECEIVING MEDICAID SERVICES. PLEASE KEEP THIS CARD FOR YOUR RECORDS. IF YOU HAVE QUESTIONS ON MEDICAL COVERAGE CALL MEDICAID AT 1-800-662-9651. IF YOU HAVE QUESTIONS ON MENTAL HEALTH COVERAGE CALL [Prepaid Mental Health Plan] AT [PMHP phone number]. FOR NON-EMERGENCY TRANSPORTATION SERVICES CALL 1-888-822-1048. IF YOU HAVE QUESTIONS REGARDING THE USE OF THIS CARD OR QUESTIONS ON DENTAL OR PHARMACY, PLEASE CONTACT MEDICAID INFORMATION AT 538-6155 OR TOLL FREE AT 1-800-662-9651. ANY ATTEMPT TO MODIFY THIS CARD IN ANY WAY OR ALLOW USE BY UNAUTHORIZED PERSONS CONSTITUTES FRAUD.

PROVIDER: IF THERE ARE ANY CHANGES ON INSURANCE COVERAGE, CALL THE TPL UNIT AT 1-800-821-2237. PLEASE KEEP A COPY OF THIS CARD FOR YOUR RECORDS. THIS IS THE END OF THE MEDICAID IDENTIFICATION CARD.**********000191919 AM

Ø HMO indicator.

Ù Medical services covered by United MedChoice.
*Managed care plans do not cover pharmacy, dental, or chiropractic services. The client may choose a provider who accepts Medicaid for the service needed.

HMO: HEALTHY U

This Medicaid Identification Card states name of Health Maintenance Organization (HMO) below eligibility information and above the client's name. Card is not valid for services from any other health care supplier or provider (HMO, physician, hospital facility, home health, medical supplier, etc.) without a referral from the HMO identified. Pharmacy and dental services may be provided by any Medicaid participating pharmacist/dentist. Standard information is explained with an example on page 3. Information unique to this card is marked with a numbered circle. Refer to explanation of numbers below.

Reference: Utah Medicaid Provider Manual, SECTION 1, Chapter 4, Managed Care Plans.

NOTE: **Effective November 1, 1998, the former University Health Network changed its name to Healthy U.**

Ø HMO indicator

Ù Medical services covered by the managed care plan.
*Managed care plans do not cover pharmacy, dental, or chiropractic services. The client may choose a provider who accepts Medicaid for the service needed.

DEPARTMENT OF WORKFORCE SERVICES
158 SOUTH 200 WEST
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NON-NEGOTIABLE

JANE DOE
1234 FIRST STREET
ANYTOWN UT 84000

NON-NEGOTIABLE

MEDICAID IDENTIFICATION CARD

UTAH DEPARTMENT OF HEALTH

ELIGIBLE FROM - JUNE 1, 2002 THRU JUNE 30, 2002

THIS ID CARD ENTITLES THE FOLLOWING NAMED PERSONS TO MEDICAL/DENTAL/PHARMACY SERVICES.

Ø **HEALTHY U**	**HEALTHY U**		**HEALTHY U**		**HEALTHY U**	
NAME	ID	SEX	DOB	AGE		MEDICAL/PHARMACY
DOE, JANE	9999999999	F	01APR37	65	Ù	Healthy U MENTAL HEALTH SERVICES VALLEY MENTAL HEALTH

COPAY/CO-INS FOR: NON EMERGENCY USE OF ER, OUTPAT HOSP & PHYSICIAN SVCS, PHARMACY, INPAT HOSP

* *

CLIENT: THIS CARD MUST BE PRESENTED BEFORE RECEIVING MEDICAID SERVICES. PLEASE KEEP THIS CARD FOR YOUR RECORDS. IF YOU HAVE QUESTIONS ON MEDICAL COVERAGE CALL MEDICAID AT 1-800-662-9651. IF YOU HAVE QUESTIONS ON MENTAL HEALTH COVERAGE CALL [Prepaid Mental Health Plan] AT [PMHP phone number]. FOR NON-EMERGENCY TRANSPORTATION SERVICES CALL 1-888-822-1048. IF YOU HAVE QUESTIONS REGARDING THE USE OF THIS CARD OR QUESTIONS ON DENTAL OR PHARMACY, PLEASE CONTACT MEDICAID INFORMATION AT 538-6155 OR TOLL FREE AT 1-800-662-9651. ANY ATTEMPT TO MODIFY THIS CARD IN ANY WAY OR ALLOW USE BY UNAUTHORIZED PERSONS CONSTITUTES FRAUD.

PROVIDER: IF THERE ARE ANY CHANGES ON INSURANCE COVERAGE, CALL THE TPL UNIT AT 1-800-821-2237. PLEASE KEEP A COPY OF THIS CARD FOR YOUR RECORDS. THIS IS THE END OF THE MEDICAID IDENTIFICATION CARD.**********000191919 AM

PRIMARY CARE PROVIDER

This Medicaid Identification Card states PRIMARY PROVIDER below eligibility information and above the client's name. Name of the Primary Care Provider is printed next to each client's name. Card is not valid for services from any other physician without a referral from the Primary Care Provider. Pharmacy and dental services may be provided by any Medicaid participating pharmacist/dentist. Standard information is explained with an example on page 3. Information unique to the Primary Care Provider Card is marked with a numbered circle. Refer to explanation of numbers below.

Reference: Utah Medicaid Provider Manual, SECTION 1, Chapter 2, Covered Services, and Chapter 6 - 9, Physician Referrals

Ø Primary Care Provider indicator

Ù Primary Care Provider identified. Referral required for any other medical provider

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1234 FIRST STREET
ANYTOWN UT 84000

NON-NEGOTIABLE

MEDICAID IDENTIFICATION CARD

UTAH DEPARTMENT OF HEALTH

ELIGIBLE FROM - JUNE 1, 2002 THRU JUNE 30, 2002

THIS ID CARD ENTITLES THE FOLLOWING NAMED PERSONS TO MEDICAL/DENTAL/PHARMACY SERVICES.

Ø **PRIMARY PROVIDER** NAME	ID	TPL SEX	DOB	AGE	**PRIMARY PROVIDER** PRIMARY CARE PHYSICIAN
DOE, JANE	9999999999	F	01APR62	40	Ù Rural Health Clinic

Dental
A participating dentist
MENTAL HEALTH SERVICES
Four Corners Mental Health

COPAYMENT REQUIRED FOR NON EMERGENCY USE OF THE ER ROOM
THIRD PARTY: MAILHANDLERS
FOUR CORNERS MENTAL HEALTH
POLICY HOLDER: DOE, JOHN

DOE, JOHN 8888888888 (F) M 01APR82 18

PRIMARY CARE PHYSICIAN
Rural Health Clinic
Dental
A participating dentist
MENTAL HEALTH SERVICES
Four Corners Mental Health

THIRD PARTY: MAILHANDLERS
POLICY HOLDER: DOE, JOHN
NO CO-PAYMENT REQUIRED

* *

CLIENT: THIS CARD MUST BE PRESENTED BEFORE RECEIVING MEDICAID SERVICES. PLEASE KEEP THIS CARD FOR YOUR RECORDS. IF YOU HAVE QUESTIONS ON MEDICAL COVERAGE CALL MEDICAID AT 1-800-662-9651. IF YOU HAVE QUESTIONS ON MENTAL HEALTH COVERAGE CALL [Prepaid Mental Health Plan] AT [PMHP phone number]. FOR NON-EMERGENCY TRANSPORTATION SERVICES CALL 1-888-822-1048. IF YOU HAVE QUESTIONS REGARDING THE USE OF THIS CARD OR QUESTIONS ON DENTAL OR PHARMACY, PLEASE CONTACT MEDICAID INFORMATION AT 538-6155 OR TOLL FREE AT 1-800-662-9651. ANY ATTEMPT TO MODIFY THIS CARD IN ANY WAY OR ALLOW USE BY UNAUTHORIZED PERSONS CONSTITUTES FRAUD.
PROVIDER: IF THERE ARE ANY CHANGES ON INSURANCE COVERAGE, CALL THE TPL UNIT AT 1-800-821-2237. PLEASE KEEP A COPY OF THIS CARD FOR YOUR RECORDS.
THIS IS THE END OF THE MEDICAID IDENTIFICATION CARD.**********000191919 FM

RESTRICTED MEDICAID ELIGIBILITY

This Medicaid Identification Card states "RESTRICTED" below eligibility information and above the client's name. Client may only receive services from the providers and pharmacy identified, unless there is a referral from the Primary Care Provider. Dental services may be provided by any Medicaid participating dentist. Standard information is explained with an example on page 3. Information unique to the Restricted Card is marked with a numbered circle. Refer to explanation of numbers below.

Reference: Utah Medicaid Provider Manual, SECTION 1, Chapter 1 - 5, Restriction Program.

Ø Pharmacy services restricted to provider named

DEPARTMENT OF WORKFORCE SERVICES
158 SOUTH 200 WEST
P.O. BOX 45490
SALT LAKE CITY UT 84145

NON-NEGOTIABLE

JANE DOE
1234 FIRST STREET
ANYTOWN UT 84000

NON-NEGOTIABLE

MEDICAID IDENTIFICATION CARD

UTAH DEPARTMENT OF HEALTH

ELIGIBLE FROM - JUNE 1, 2002 THRU JUNE 30, 2002

THIS ID CARD ENTITLES THE FOLLOWING NAMED PERSONS TO MEDICAL/DENTAL/PHARMACY SERVICES.

RESTRICTED **RESTRICTED** **RESTRICTED**

NAME	ID	SEX	DOB	AGE	MEDICAL/PHARMACY
DOE, JANE	9999999999	F	01APR37	65	HMO, Clinic, Primary Care Provider

Ø Name of specific pharmacy (example: Harmons West #1)

DENTAL
A participating dentist

MENTAL HEALTH SERVICES
VALLEY MENTAL HEALTH

Copayment Required for Pharmacy

****

CLIENT: THIS CARD MUST BE PRESENTED BEFORE RECEIVING MEDICAID SERVICES. PLEASE KEEP THIS CARD FOR YOUR RECORDS. IF YOU HAVE QUESTIONS ON MEDICAL COVERAGE CALL MEDICAID AT 1-800-662-9651. IF YOU HAVE QUESTIONS ON MENTAL HEALTH COVERAGE CALL [Prepaid Mental Health Plan] AT [PMHP phone number]. FOR NON-EMERGENCY TRANSPORTATION SERVICES CALL 1-888-822-1048. IF YOU HAVE QUESTIONS REGARDING THE USE OF THIS CARD OR QUESTIONS ON DENTAL OR PHARMACY, PLEASE CONTACT MEDICAID INFORMATION AT 538-6155 OR TOLL FREE AT 1-800-662-9651. ANY ATTEMPT TO MODIFY THIS CARD IN ANY WAY OR ALLOW USE BY UNAUTHORIZED PERSONS CONSTITUTES FRAUD.

PROVIDER: IF THERE ARE ANY CHANGES ON INSURANCE COVERAGE, CALL THE TPL UNIT AT 1-800-821-2237. PLEASE KEEP A COPY OF THIS CARD FOR YOUR RECORDS. THIS IS THE END OF THE MEDICAID IDENTIFICATION CARD.**********000191919 AM

NON-TRADITIONAL MEDICAID PROGRAM

This Identification Card states "NON-TRADITIONAL MEDICAID PROGRAM" at the top. The top third of the card is a tear-away with the client's name and address. The Card is printed on white card stock with a blue background behind the name and address and a blue Department of Health logo on the background of the card. Covered services may be provided by any Medicaid participating dentist. Standard information is explained with an example on page 3.

Reference: Utah Medicaid Provider Manual, SECTION titled "NON-TRADITIONAL MEDICAID PROGRAM".

NOTE: The first month this card was issued was July 1, 2002.

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158 SOUTH 200 WEST
P.O. BOX 45490
SALT LAKE CITY UT 84145

NON-NEGOTIABLE

JANE DOE
1234 FIRST STREET
ANYTOWN UT 84000

NON-NEGOTIABLE

NON TRADITIONAL MEDICAID IDENTIFICATION CARD

UTAH DEPARTMENT OF HEALTH

ELIGIBLE FROM - JULY 1, 2002 THRU JULY 31, 2002

THIS ID CARD ENTITLES THE FOLLOWING NAMED PERSONS TO MEDICAL/DENTAL/PHARMACY SERVICES.

* *

NAME	ID	SEX	DOB	AGE	MENTAL HEALTH SERVICES
DOE, JANE	9999999999	F	01APR62	40	**WEBER MENTAL HEALTH**

COPAY/CO-INS FOR: NON-EMERGENCY USE OF THE ER, OUPAT HOSP & PHYSICIAN SVCS, PHARMACY, INPT HOSP

* *

CLIENT: THIS CARD MUST BE PRESENTED BEFORE RECEIVING MEDICAID SERVICES. PLEASE KEEP THIS CARD FOR YOUR RECORDS. IF YOU HAVE QUESTIONS ON MEDICAL COVERAGE CALL MEDICAID AT 1-800-662-9651. IF YOU HAVE QUESTIONS ON MENTAL HEALTH COVERAGE CALL WEBER AT 1-801-625-3700. IF YOU HAVE QUESTIONS REGARDING THE USE OF THIS CARD OR QUESTIONS ON DENTAL OR PHARMACY, PLEASE CONTACT MEDICAID INFORMATION AT 538-6155 OR TOLL FREE AT 1-800-662-9651. ANY ATTEMPT TO MODIFY THIS CARD IN ANY WAY OR ALLOW USE BY UNAUTHORIZED PERSONS CONSTITUTES FRAUD.

PROVIDER: IF THERE ARE ANY CHANGES ON INSURANCE COVERAGE, CALL THE TPL UNIT AT 1-800-821-2237. PLEASE KEEP A COPY OF THIS CARD FOR YOUR RECORDS. THIS IS THE END OF THE NON TRADITIONAL MEDICAID IDENTIFICATION CARD.
***000191919 FM

PREPAID MENTAL HEALTH PLAN FOR INPATIENT SERVICES ONLY (Foster Care)

This Medicaid Identification Card states name of Prepaid Mental Health Plan under the Mental Health Services information. The plan is responsible for *inpatient psychiatric services only*. The client may obtain *outpatient* mental health services from any participating Medicaid provider. This unique information is marked with a numbered circle.

Reference: Utah Medicaid Provider Manual, SECTION 1, Chapter 13 - 5, Children in State Custody (Foster Care); SECTION 2, MENTAL HEALTH SERVICES.

DEPARTMENT OF WORKFORCE SERVICES
158 SOUTH 200 WEST
P.O. BOX 45490
SALT LAKE CITY UT 84145

NON-NEGOTIABLE

JANE DOE
1234 FIRST STREET
ANYTOWN UT 84000

NON-NEGOTIABLE

MEDICAID IDENTIFICATION CARD

UTAH DEPARTMENT OF HEALTH

ELIGIBLE FROM - JUNE 1, 2002 THRU JUNE 30, 2002

THIS ID CARD ENTITLES THE FOLLOWING NAMED PERSONS TO MEDICAL/DENTAL/PHARMACY SERVICES.

AFC-Utah NAME	TPL ID	SEX	AFC-Utah DOB	AGE	TPL MEDICAL/PHARMACY
DOE, JANE	9999999999 (F)	F	01APR92	10	AFC

DENTAL
NO CO-PAYMENT REQUIRED
A participating dentist

Ø MENTAL HEALTH SERVICES
Inpatient Psych: Valley MHC
Outpatient Psych: Any Participating Provider

THIRD PARTY: PEHP
POLICY HOLDER: John Doe

* *

CLIENT: THIS CARD MUST BE PRESENTED BEFORE RECEIVING MEDICAID SERVICES. PLEASE KEEP THIS CARD FOR YOUR RECORDS. IF YOU HAVE QUESTIONS ON MEDICAL COVERAGE CALL MEDICAID AT 1-800-662-9651. IF YOU HAVE QUESTIONS ON MENTAL HEALTH COVERAGE CALL [Prepaid Mental Health Plan] AT [PMHP phone number]. FOR NON-EMERGENCY TRANSPORTATION SERVICES CALL 1-888-822-1048. IF YOU HAVE QUESTIONS REGARDING THE USE OF THIS CARD OR QUESTIONS ON DENTAL OR PHARMACY, PLEASE CONTACT MEDICAID INFORMATION AT 538-6155 OR TOLL FREE AT 1-800-662-9651. ANY ATTEMPT TO MODIFY THIS CARD IN ANY WAY OR ALLOW USE BY UNAUTHORIZED PERSONS CONSTITUTES FRAUD.

PROVIDER: IF THERE ARE ANY CHANGES ON INSURANCE COVERAGE, CALL THE TPL UNIT AT 1-800-821-2237. PLEASE KEEP A COPY OF THIS CARD FOR YOUR RECORDS. THIS IS THE END OF THE MEDICAID IDENTIFICATION CARD.**********000191919 FC

Ø Prepaid Mental Health Plan for inpatient psychiatric services only. For outpatient mental health, client may use any appropriate Medicaid provider.

FORM MEEU ATTACHED TO MEDICAID CARD

This Medicaid Identification Card has message "IMPORTANT! MEDICAID WILL NOT PAY FOR SERVICES ON ATTACHED FORM "MEEU"! below eligibility information and above the client's name. Client may receive services from any Medicaid provider. However, providers whose services are listed on the attached MEEU will not be reimbursed by Medicaid for the patient's financial obligation. Standard information is explained with an example on page 3. Information unique to the Card with MEEU attached is marked with a numbered circle. Refer to explanation of numbers below.

Reference: Utah Medicaid Provider Manual, SECTION 1, Chapter 6 - 8, Exceptions to Prohibition on Billing Clients, item 2.

DEPARTMENT OF WORKFORCE SERVICES
158 SOUTH 200 WEST
P.O. BOX 45490
SALT LAKE CITY UT 84145

NON-NEGOTIABLE

JANE DOE
1234 FIRST STREET
ANYTOWN UT 84000

NON-NEGOTIABLE

MEDICAID IDENTIFICATION CARD

UTAH DEPARTMENT OF HEALTH

ELIGIBLE FROM - JUNE 1, 2002 THRU JUNE 30, 2002

THIS ID CARD ENTITLES THE FOLLOWING NAMED PERSONS TO MEDICAL/DENTAL/PHARMACY SERVICES.

Ø **"IMPORTANT! MEDICAID WILL NOT PAY FOR SERVICES ON ATTACHED FORM 'MEEU'!"**

NAME	ID	SEX	DOB	AGE	MEDICAL/PHARMACY
DOE, JANE	9999999999	F	01APR37	65	A participating provider
					DENTAL
					Any participating dentist
					MENTAL HEALTH SERVICES
					VALLEY MENTAL HEALTH

Copayment Required for Pharmacy

* *

CLIENT: THIS CARD MUST BE PRESENTED BEFORE RECEIVING MEDICAID SERVICES. PLEASE KEEP THIS CARD FOR YOUR RECORDS. IF YOU HAVE QUESTIONS ON MEDICAL COVERAGE CALL MEDICAID AT 1-800-662-9651. IF YOU HAVE QUESTIONS ON MENTAL HEALTH COVERAGE CALL [Prepaid Mental Health Plan] AT [PMHP phone number]. FOR NON-EMERGENCY TRANSPORTATION SERVICES CALL 1-888-822-1048. IF YOU HAVE QUESTIONS REGARDING THE USE OF THIS CARD OR QUESTIONS ON DENTAL OR PHARMACY, PLEASE CONTACT MEDICAID INFORMATION AT 538-6155 OR TOLL FREE AT 1-800-662-9651. ANY ATTEMPT TO MODIFY THIS CARD IN ANY WAY OR ALLOW USE BY UNAUTHORIZED PERSONS CONSTITUTES FRAUD.

PROVIDER: IF THERE ARE ANY CHANGES ON INSURANCE COVERAGE, CALL THE TPL UNIT AT 1-800-821-2237. PLEASE KEEP A COPY OF THIS CARD FOR YOUR RECORDS. THIS IS THE END OF THE MEDICAID IDENTIFICATION CARD.**********000191919 AM

Ø Form MEEU indicator.

INSTRUCTIONS FOR FORM MEEU

The Medicaid client has assumed responsibility to pay a portion of their medical bills. Medicaid will NOT pay the portion of the bill that is the client's financial obligation. Form MEEU lists the bills and the amount of the client's obligation. Form MEEU is titled "Medical Expenses Used." It lists each medical service for that month for which the client has financial responsibility. On the MEEU below are two examples of a client's financial obligation for medical services.
Reference: Utah Medicaid Provider Manual, SECTION 1, Chapter 6 - 8, Exceptions to Prohibition on Billing Clients, item 2.

- Ø Number of pages for form
- Ù Date form issued
- Ú Name of responsible client
- Û Month of Eligibility
- Ü Instructions to client
- Ý Patient Medicaid I.D. number
- Þ Patient name
- ß Provider name & address
- à Date of service
- á Type of service
- ⓫ Total bill, according to patient
- ⓬ Client's financial obligation. Medicaid deducts this amount from the reimbursement amount.
- ⓭ Instruction to provider (Do not bill a partial charge. Medicaid deducts client's obligation from amount billed.) Because the client obligation is equal to the entire charge, the Medicaid reimbursement will be zero.

DEPARTMENT OF WORKFORCE SERVICES
2540 WASHINGTON BLVD.
P. O. BOX 349
OGDEN UT 84402-349

JANE DOE
1234 FIRST STREET
ANYTOWN UT 84000 MEEU

Ø
PAGE 1 OF 1
Ù
29JUN02 17:10

MEDICAL EXPENSE USED

WARNING! MEDICAID WILL NOT PAY ALL CLAIMS FOR ELIGIBLE CLIENTS!

Ú CASE NAME: DOE, JANE CASE NUMBER: 123456
Û BENEFIT MONTH: JUN02

Ü YOU AGREE TO PAY CHARGES LISTED BELOW. EACH PROVIDER MAY BILL YOU FOR THE AMOUNT YOU OWE. THE PROVIDER MAY ALSO BILL MEDICAID WHEN THE CHARGE FOR A SERVICE IS MORE THAN THE AMOUNT YOU OWE. IF YOU HAVE A QUESTION ABOUT YOUR FINANCIAL RESPONSIBILITY, PLEASE CALL YOUR MEDICAID ELIGIBILITY WORKER. YOUR PROVIDER SHOULD CALL THE MEDICAID INFORMATION LINE AT 538-6155 OR 1-800-662-9651 FOR QUESTIONS ABOUT YOUR FINANCIAL RESPONSIBILITY OR BILLING MEDICAID.

THIS MEEU REPLACES ANY MEEU WITH AN EARLIER DATE!

Ý CLIENT NUMBER: 90050777 Þ CLIENT NAME: SMITH, JOHN
ß PROVIDER NAME: DR. HENRY BROWN
PROVIDER ADDRESS: 125 WASHINGTON ST. SALT LAKE CITY, UT 84111
à BEG. DATE SERVICE: 07JUN02 END DATE SERVICE: 07JUN02
á SERVICE TYPE: PHYSICIAN
THE TOTAL MEDICAL BILL IS $250.00.
⓬ THE CLIENT IS RESPONSIBLE TO PAY $125.00 FOR THIS SERVICE.
⓭ THE TOTAL CHARGE MAY BE BILLED TO MEDICAID.

CLIENT NUMBER: 90050777 CLIENT NAME: SMITH, JOHN
PROVIDER NAME: DR. HENRY BROWN
PROVIDER ADDRESS: 125 WASHINGTON ST. SALT LAKE CITY, UT 84111
BEG. DATE SERVICE: 15JUN02 END DATE SERVICE: 15JUN02
SERVICE TYPE: PHYSICIAN
⓫ THE TOTAL MEDICAL BILL IS $75.00.
⓬ THE CLIENT IS RESPONSIBLE TO PAY $75.00 FOR THIS SERVICE.
⓭ MEDICAID WILL PAY $0.00 FOR THIS SERVICE.

FOR QUESTIONS ABOUT CLIENT'S FINANCIAL RESPONSIBILITY FOR SERVICES ON THIS FORM, PLEASE CALL THE MEDICAID ELIGIBILITY WORKER AT (801) 123-4567.

END OF MEEU

INTERIM VERIFICATION OF MEDICAID ELIGIBILITY: FORM 695

Form 695 is printed on 8 1/2 x 11 white paper. Card is a substitute for the Medicaid card. If a stamped message "NOT VALID WITHOUT MEEU ATTACHED" appears on form, refer to instructions for Form MEEU.
Reference: Utah Medicaid Provider Manual, SECTION 1, Chapter 5 - 2, Interim Verification (Form 695)

Ø Box 1: Indicates local Medicaid Office

Ù Period of validity

Ú Client's name and identification number: either a 10 digit number, or 9 digits with an X or 8 digits with TX

Û Name of the Primary Care physician, HMO enrollment, and/or Prepaid Mental Health Plan follow client's number

Ü Type of medical plan

Ý Code for Co-Pay

ò Pharmacy

ó Third Party Liability (insurance) information

ô Signature of Medicaid eligibility worker

Utah-DOH-BES
Form 695P 05/02

24 30 122

Ø _____ Office

UTAH DEPARTMENT OF HEALTH
INTERIM VERIFICATION OF MEDICAL ELIGIBILITY

TO MEDICAL PROVIDERS: This form serves as interim verification of eligibility while a medical card is being produced for newly approved recipients or to replace a stolen/lost card.

- The eligibility period cannot extend more than 30 days past the day the form is signed.
- If the Primary Physician, HMO area is blank, then any physician may render service. If a HMO is identified, then services must be provided by that HMO. These areas do not apply to any other provider types.
- When you submit your claim to Medicaid, be sure to include the correct ID Number of the patient on your claim form.
- A Plan Type and Co-pay Code must be listed for each individual on this form.
- Please return the Form 695P to the Medicaid client.

The following persons are eligible to receive Title XIX Medicaid services during the period. (Not to exceed 30 days)

Ù Dates _____ to _____

Ú Û Ü Ý

NAME	ID NUMBER	PRIMARY PHYSICIAN OR HMO	PLAN TYPE* (Required Field)	CO-PAY CODE** (Required Field)
	_ _ _ _ _ _ _ _ _ _ _X			
	_ _ _ _ _ _ _ _ _ _ _X			
	_ _ _ _ _ _ _ _ _ _ _X			
	_ _ _ _ _ _ _ _ _ _ _X			
	_ _ _ _ _ _ _ _ _ _ _X			
	_ _ _ _ _ _ _ _ _ _ _X			

*** PLAN TYPE** **Traditional Medicaid - TM Non-Traditional - NT PCN - PC**
****CO-PAY CODES:** A. Non-Emergency Use of the ER, Outpatient Hospital & Physician Services, & Pharmacy
B. No Co-Pay Required

Þ Pharmacy is _____ **(Required field)**

ß The client(s) have health insurance with _____ **(Please bill insurance prior to billing Medicaid)**

à _____ **Signature of Authorized Representative** _____ **Date**

FOR STATE USE ONLY

Case Name_____ Case Number_____ Program Type_____ Team___
Address_____
HMO status is ☐ Active ☐ Pending

FORM MI-706: UMAP REIMBURSEMENT AGREEMENT

Form MI 706, UMAP REIMBURSEMENT AGREEMENT, is printed on 8 1/2 x 11 white paper. This form is used to authorize services for the Utah Medical Assistance Program (UMAP).

Reference: Utah Medicaid Provider Manual, SECTION 1, Chapter 13 - 2, Utah Medical Assistance Program.

Note: UMAP program discontinued June 30, 2002.

Ø Instructions to provider

Ù Preprinted authorization number

Ú Client information

Û Dates of Eligibility – strictly limited

Ü Patient symptoms indicated

Ý Authorized services

Þ Health Care Provider identified.

ß Date, office, telephone number and signature of certifying worker

UMAP
Reimbursement Agreement
(MI-706)

Ø The individual named below has been found to have a medical condition which is within the limited scope of service of the Utah Medical assistance Program (UMAP). UMAP agrees to provide reimbursement for treatment of this covered condition. Brief instructions regarding reimbursement procedures are provided on the reverse side of this form.

If this person has any insurance to cover this service, the providers must first fill the insurance. Any claim which is submitted must reflect the payment from the insurance.

Ù

Prior Authorization Number Nº 0000000

Ú

1. Last Name	2. First Name	3. Initial	4. Date of Birth	5. Sex
6. Client I.D. Number	Û 7. Date of Eligibility From: To:			8. County Code

Ü UMAP will provider reimbursement for treatment of the following condition(s) and/or symptoms:

Line No.	10. Description of condition(s) and/or symptom(s):
1	
2	
3	

Ý UMAP will provide reimbursement for the following services:

Line No.	12. Identification of Authorized Service(s)	13. Unit(s)	14. Code(s)
1			
2			
3			
4			

Þ 15. _____
Provider Name

ß
17. _____ 18. _____ 19. _____
M M D D Y Y Form and Program Reviewer ID
20. _____ _____
Certifying Signature Telephone

FORM MI-706: REQUEST FOR MEDICAL INFORMATION (Administrative Physicals)

The Department of Workforce Services uses a unique form to request an administrative physical required to determine Medicaid eligibility based on the applicant's ability to work. The completed medical information form should be returned to the eligibility worker as directed, and the reimbursement agreement should be retained by the provider for his or her records. The form is printed on 8 1/2 x 11 white paper. For more information, please refer to the October 1996 Medicaid Information Bulletin, *New Billing Form and Process for Reimbursement for Administrative Physicals.*

Ø Instructions to provider

Ù Preprinted authorization number

Ú Client information

Û Dates of Eligibility – strictly limited

Ü Services will be indicated

Ý CPT codes for services covered

Þ Health Care Provider identified

ß Date, office, telephone number and signature of certifying worker

Division of Health Care Financing (DHCF)
Reimbursement Agreement
(MI-706)

Request for Medical Information

Ø The State of Utah is in need of medical and/or psychiatric information about the individual named below. We ask that you provide your findings: 1. By providing copies of your medical records, or 2. By completion of the attached Medical report, (completion of a typed report which includes information requested in the relevant sections of the report form is an acceptable alternative). If you cannot complete the report without doing tests and/or x-rays in addition to the exam, call the Administrative Physical Health Program Representative indicated on the back of this form, and they will determine whether or not reimbursement can be provided for the additional services. Brief instructions regarding reimbursement procedures are provided on the reverse side of this form.

Ù

Prior Authorization Number
Nº 0000000

Ú

1. Last Name	2. First Name	3. Initial	4. Date of Birth	5. Sex

6. Client I.D. Number	Û 7. Date of Eligibility From: To:	8. County Code

Ü DHCF will provide reimbursement for:

9.*	10. SERVICE
	provide Medical records only (bill Y9051**)
	Completion of the attached form, or a typed report (bill Y9055** if no exam performed), and exam if necessary
	Lab test(s)
	X-ray(s) and x-ray interpretation
	Other, specifically:

*X in this column indicates which services are authorized for reimbursement
**Not a Medicaid benefit, paid from another funding source

Ý CPT codes which are authorized for reimbursement are:

11.	12. Service(s)	13. Unit(s)	14. Code(s)
1	As indicated by a check in column 9	**1**	
2			
3			
4			

Þ 15. _____ Provider Name

ß 17. _____ (M M D D Y Y) 18. _____ (Form and Program) 19. _____ (Reviewer ID)

20. _____ (Certifying Signature) _____ (Telephone)

FORM MI-706: STATE MEDICAL SERVICES PROGRAM (Custody Medical Care/Foster Care)

The Department of Human Services uses a unique form to authorize health care services for a person eligible for a State Medical Services Program. When Form MI-706 titled STATE MEDICAL SERVICES is authorized, the claim is processed and reimbursed as if it were a Medicaid claim. The form is printed on 8 1/2 x 11 white paper. As an example of a State Medical Services Program, refer to SECTION 1, Chapter 13 - 4, Custody Medical Care Program, and Chapter 13 - 5, Children in State Custody (Foster Care).

Ø Instructions to provider

Ù Preprinted authorization number

Ú Client information

Û Dates of Eligibility – strictly limited

Ü Patient symptoms indicated

Ý Authorized services

Þ Health Care Provider identified.

ß Date, office, telephone number and signature of certifying worker

[redacted]

State Medical Services (SMS)
Reimbursement Agreement
(MI-706)

STATE MEDICAL SERVICES

Ø The individual named below has been found eligible to receive service under the Division of Health Care Financing - State Medical Services Program (SMS), for the dates indicated. The Division of Health Care Financing agrees to provide reimbursement for treatment, at Medicaid rates. Brief instructions regarding reimbursement procedures are provided on the reverse side of this form.

Ù

Prior Authorization Number
Nº 0000000

Ú

1. Last Name	2. First Name	3. Initial	4. Date of Birth	5. Sex

6. Client I.D. Number	Û 7. Date of Eligibility From: To:	8. County Code

Ü SMS will provider reimbursement for the following condition(s) and/or symptoms:

Line No.	10. Description of condition(s) and/or symptom(s):
1	
2	
3	

Ý SMS will provide reimbursement for the following services:

Line No.	12. Identification of Authorized Service(s)	13. Unit(s)	14. Code(s)
1			
2			
3			
4			

Þ 15. _____
Provider Name

ß

17. _____ 18. _____ 19. _____
M M D D Y Y Form and Program Reviewer ID

20._____ _____
Certifying Signature Telephone

"BABY YOUR BABY" IDENTIFICATION CARD

The "Baby Your Baby" Form is printed on pink cardstock, size 8.5" by 5.5". This form entitles the eligible woman to outpatient pregnancy related services. Note the expiration date on the form. **Card must be shown every time service is given! Dates of eligibility strictly limited to the dates on client's card.**

Reference: Utah Medicaid Provider Manual, SECTION 1, Chapter 13 - 1, Presumptive Eligibility Program

- Ø Dates of eligibility (See also Þ)
- Ù Client name
- Ú Client I.D. number which ends with **"V"**
- Û TPL Information (Insurance)
- Ü Reminder of service limitations
- Ý Name, address,& phone number of provider who determined client eligibility
- Þ A Medicaid Eligibility worker may extend the end date of eligibility. If so, worker enters new expiration date and signature in this area.
- ß Billing information

UTAH DEPARTMENT OF HEALTH
COMMUNITY and FAMILY HEALTH SERVICES DIVISION
PRESUMPTIVE ELIGIBILITY/ PERINATAL PROGRAM

Utah Department of Health IDENTIFICATION CARD **Baby Your Baby**

Ø Eligibility from ___ ___ / ___ ___ / ___ ___ thru: ___ ___ / ___ ___ / ___ ___
M M D D Y Y M M D D Y Y

Ù Client Name_____ Ú I.D. No:_ _ _ - _ _-_ _ _ _**V** Birthdate:__/__/___
Last First MI Mo Day Yr

Û Health Insurance:_____ Ý Qualified Provider:_____

Address:_____ Address:_____

_____ _____

Name of Insured:_____ Phone #:_____

Group #:_____ I.D.#:_____ _____

Employer:_____ Þ Signature of the Qualified Provider Worker

Ü I certify that the above information is correct. I understand that this card entitles me to outpatient pregnancy related services. No delivery/ childbirth expenses are covered by this card.

ß **Send claims to:**
Utah Department of Health
Bureau of Medicaid Operations
Box 143106
Salt Lake City UT 84114-3106

_____ _____
Signature of Client Date

For billing or eligibility questions: Salt Lake area (801) 538-6155. Outside Salt Lake area call: 1-800-662-9651

WARNING: ANY ALTERATION OF THIS CARD VOIDS THE CARD IMMEDIATELY.

BACK OF CARD

BILLING INSTRUCTIONS

To the client:

1. You need to apply for Medicaid at the Department of Workforce/Eligibility Services by the expiration date on the front of this card. You are urged to do this as soon as possible.
2. You must take this card with you for services to be provided.
3. If your card is nearing expiration and you have not been approved or denied Medicaid, contact your caseworker at the Department of Workforce/Eligibility Services.
4. This card must be returned to your qualified provider when:
   a. You have been notified of approval or denial for Medicaid, or
   b. It expires.
5. Always take this card with you to any appointments with the Department of Workforce/Eligibility Services

To the provider:

1. Reimbursement for services will be paid through the Utah Medicaid billing system utilizing Medicaid's reimbursement polices and payment rates. Send all claims to the address noted on the front of this card.
1. Only outpatient pregnancy related services will be reimbursed. No claims for deliveries, global fees, or any inpatient services will be reimbursed under the Presumptive Eligibility (Baby Your Baby) Program.
3. No reimbursement for covered Medicaid services will be made by this program if payments for such services can be obtained from other third party sources.
4. Any extension of eligibility can be granted only by the client's Department of Workforce/Eligibility Services caseworker and must be indicated by the authorized stamp on the front of this card.
6. If you have any questions on the client's eligibility, please contact:

_____ _____ _____
Qualified Provider Phone # Perinatal Care Coordinator
(Please type or print)

EMERGENCY SERVICES PROGRAM

This Medical Assistance Identification Card states "EMERGENCY SERVICES" below eligibility information and above the client's name. Client may receive emergency services as specified by Medicaid. Standard information is explained with an example on page 3. Information unique to the Emergency Services Card is marked with a numbered circle. Refer to explanation of numbers below.

Reference: Utah Medicaid Provider Manual, SECTION 1, Chapter 13 - 8, Emergency Services Program.

Ø Reminder about Emergency Services Program

Ù Emergency Services indicator

Ú No health care providers identified because service limited to medical emergencies only

DEPARTMENT OF WORKFORCE SERVICES
158 SOUTH 200 WEST
P.O. BOX 45490
SALT LAKE CITY UT 84145

NON-NEGOTIABLE

JANE DOE
1234 FIRST STREET
ANYTOWN UT 84000

NON-NEGOTIABLE

MEDICAID IDENTIFICATION CARD

UTAH DEPARTMENT OF HEALTH

ELIGIBLE FROM - JUNE 1, 2002 THRU JUNE 30, 2002

Ø THIS ID CARD ENTITLES THE FOLLOWING NAMED PERSONS TO EMERGENCY SERVICES ONLY.

Ù **EMERGENCY SERVICES** **EMERGENCY SERVICES**

NAME	ID	SEX	DOB	AGE	Ú
DOE, JANE	9999999999	F	01APR62	40	

* *

CLIENT: THIS CARD IS ONLY VALID FOR EMERGENCY SERVICES. ANY ATTEMPT TO MODIFY THIS CARD IN ANY WAY OR ALLOW USE BY UNAUTHORIZED PERSONS CONSTITUTES FRAUD.

PROVIDER: THIS CARD IS VALID FOR EMERGENCY SERVICES ONLY (AS DEFINED IN SECTION 1 OF YOUR PROVIDER MANUAL) ALL SERVICES WILL BE REVIEWED PRIOR TO PAYMENT BY THE DIVISION OF HEALTH CARE FINANCING. PLEASE KEEP A COPY OF THIS CARD FOR YOUR RECORDS. IF YOU HAVE QUESTIONS OR NEED INFORMATION, PLEASE CALL THE MEDICAL INFORMATION UNIT AT 538-6155 OR CALL TOLL FREE 1 (800) 662-9651. THIS IS THE END OF THE IDENTIFICATION CARD.**********000191919 EM

QUALIFIED MEDICARE BENEFICIARY (QMB)

This Medicaid Identification Card is printed on white card stock with peach background behind name and address and a peach logo for the Department of Health on the background. The words "QUALIFIED MEDICARE BENEFICIARY" are printed below the eligibility information and above the client's name. This card is valid for Medicare co-payments and deductibles. It is not valid for Medicaid services. Standard information is explained with an example on page 3. Information unique to the QMB Card is marked with a numbered circle. Refer to explanation of numbers below.
Reference: Utah Medicaid Provider Manual, SECTION 1, Chapter 13 - 6, Qualified Medicare Beneficiary Program,

Ø QMB Program reminder

Ù QMB indicator

Ú Medicare number information

DEPARTMENT OF WORKFORCE SERVICES
158 SOUTH 200 WEST
P.O. BOX 45490
SALT LAKE CITY UT 84145

NON-NEGOTIABLE

JANE DOE
1234 FIRST STREET
ANYTOWN UT 84000

NON-NEGOTIABLE

QUALIFIED MEDICARE BENEFICIARY COVERAGE

UTAH DEPARTMENT OF HEALTH

ELIGIBLE FROM - JUNE 1, 2002 THRU JUNE 30, 2002

Ø THE FOLLOWING QMB BENEFICIARY/IES ARE ELIGIBLE FOR MEDICARE COST SHARING PAYMENT TO BE MADE BY THE UTAH QMB PROGRAM.

Ù **QMB** **QMB** **QMB** **QMB**

NAME	ID	SEX	DOB	AGE	Ú HIB #
DOE, JANE	9999999999	F	01APR25	77	528-00-0000

COPAYMENT REQUIRED FOR NON EMERGENCY USE OF THE ER ROOM.

****

CLIENT: THIS CARD MUST BE PRESENTED BEFORE RECEIVING MEDICAID SERVICES. PLEASE KEEP THIS CARD FOR YOUR RECORDS. IF YOU HAVE QUESTIONS ON MEDICAL COVERAGE CALL MEDICAID AT 1-800-662-9651. IF YOU HAVE QUESTIONS REGARDING THE USE OF THIS CARD, PLEASE CONTACT MEDICAID INFORMATION AT 538-6155 OR TOLL FREE AT 1-800-662-9651. ANY ATTEMPT TO MODIFY THIS CARD IN ANY WAY OR ALLOW USE BY UNAUTHORIZED PERSONS CONSTITUTES FRAUD.

PROVIDER: THE PERSONS LISTED ON THIS CARE ARE NOT ELIGIBLE FOR THE MEDICAID PROGRAM. COST SHARING PAYMENT WILL BE MADE FOR MEDICARE COVERED SERVICES ONLY. PLEASE DIRECT QUESTIONS ABOUT UTAH QMB COVERAGE TO 538-6155 OR TOLL FREE 1 (800) 662-9651. PLEASE SUBMIT THE CLAIM FIRST TO INSURANCE COMPANY, THEN TO MEDICARE. ANY ELIGIBLE PORTIONS OF THE CO-INSURANCE AND DEDUCTIBLE WILL BE PROCESSED AT THE SAME TIME THE MEDICARE PORTION IS PROCESSED. PAYMENT WILL BE SHOWN ON YOUR MEDICAID REMITTANCE STATEMENT. IF THERE ARE ANY CHANGES ON INSURANCE COVERAGE, CALL THE TPL UNIT AT 1-800-821-2237. PLEASE KEEP A COPY OF THIS CARD FOR YOUR RECORDS. THIS IS THE END OF THE QUALIFIED MEDICARE BENEFICIARY (QMB) IDENTIFICATION CARD.**********000191919 QM

PRIMARY CARE NETWORK

Below is a sample Identification Card for clients enrolled in the Primary Care Network Plan. The top third of the card is a tear-away with the client's name and address. The Card is printed on white card stock with a yellow background behind the name and address and a yellow Department of Health logo on the background of the card. The numbers in circles on the example card below correspond to the explanation to the left of the card.
Reference: <u>Utah Primary Care Network Provider Manual</u>, available through the Division of Health Care Financing, Utah Department of Health.
NOTE: The first month this card was issued was July 1, 2002.

Ø Dates of medical eligibility
Ù Types of services covered
Ú Primary Care Plan indicator
Û Client name
Ü Identification Number
Ý Sex is M or F: male/female
Þ Date of birth
ß Age
à Primary Care Network
á Dental care provider
⓫ Copayment requirement
⓬ Information for client
⓭ Information for provider

DEPARTMENT OF WORKFORCE SERVICES
158 SOUTH 200 WEST
P.O. BOX 45490
SALT LAKE CITY UT 84145

NON-NEGOTIABLE

JANE DOE
1234 FIRST STREET
ANYTOWN UT 84000

NON-NEGOTIABLE

PRIMARY CARE NETWORK IDENTIFICATION CARD
UTAH DEPARTMENT OF HEALTH

Ø **ELIGIBLE FROM - JULY 1, 2002 THRU JULY 31, 2002**

Ù THIS ID CARD ENTITLES THE FOLLOWING NAMED PERSON(S) TO PRIMARY CARE/PHARMACY SERVICES/BASIC DENTAL SERVICES. THIS PROGRAM DOES NOT PROVIDE INPATIENT HOSPITAL CARE OR SPECIALTY CARE

Ú PCN PCN PCN PCN PCN PCN

Û NAME	Ü ID	Ý SEX	Þ DOB	ß AGE	à <u>PRIMARY CARE NETWORK</u>
DOE, JANE	9999999999	F	01APR60	42	A PARTICIPATING PROVIDER
/	/	/	/	/	á <u>DENTAL</u>
/	/	/	/	/	A PARTICIPATING DENTIST

⓫ COPAY REQUIRED: PRIMARY CARE SERVICES, DENTAL, PHARMACY AND ER
* *
⓬ CLIENT: PRESENT THIS CARD BEFORE RECEIVING PRIMARY CARE SERVICES. PLEASE KEEP THIS CARD FOR YOUR RECORDS. IF YOU HAVE QUESTIONS ABOUT THE USE OF THIS CARD OR QUESTIONS ABOUT THE SERVICES THIS PRIMARY CARE, PROGRAM PROVIDES, PLEASE CALL MEDICAID INFORMATION AT 538-6155 OR TOLL FREE 1-800-662-9651. ANY ATTEMPT TO MODIFY THIS CARD IN ANY WAY OR ALLOW USE BY UNAUTHORIZED PERSONS CONSTITUTES FRAUD.

⓭ PROVIDER: IF THIS PATIENT HAS MEDICAL INSURANCE COVERAGE INCLUDING MEDICARE, THE PATIENT IS NOT ELIGIBLE FOR THE PRIMARY NETWORK PROGRAM. IF THERE ARE ANY CHANGES ON INSURANCE COVERAGE, CALL THE TPL UNIT 1-800-821-2237. THIS IS THE END OF THE PCN IDENTIFICATION CARD.**********000191919 PC

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